PHILADELPHIA NEUROLOGICAL SOCIETY.

October 25, 1904.

The President, Dr. C. S. Potts, in the Chair.

A Case of Hysteria.—This case was presented by Dr. Luther C. Peter. Hannah H., thirty-two years of age, a clerk, enjoyed good health until three years ago, when she gradually lost power throughout the body, staggered in walking, and in the course of a few weeks became bedridden and paralyzed. After months of treatment she improved, and was able to walk with difficulty. She now complains of unsteadiness of gait, great muscular weakness, a girdle sensation, severe at times, about the waist, and a sensation of walking on air. Sphincters are continent.

She is a small woman, of poor musculature; her gait is a mixture of ataxia, spasticity and muscular weakness. The ataxia in arms can be overcome by practice, and to some extent the same is true of the ataxia of the lower extremities. All deep reflexes are increased but variable, while clonus is present at times, and at other times there is only an attempt at clonus. Babinski's reflex is present on both sides; station is bad with eyes open, worse when closed.

There is hypesthesia in upper part of chest, but touch sense is preserved in the rest of the body. Thermic and pain senses are lost over the entire body beneath the middle of the thorax, except over right trocanter and in the region of Scarpa's triangle on the right side. Above the mid-thorax there is hypesthesia in pain and temperature senses. She cannot taste, and the faucial reflex is absent. The eye-grounds are normal. Both visual fields are concentrically contracted, and there is inversion of the red and green color fields. Cornea and sclera on the right side are anesthetic in the lower half, and in the upper half on the left side.

Although the Babinski reflex is present, it is the only constant symptom which points to organic disease. An early diagnosis of disseminated sclerosis plus hysteria was made, the sensory and eye phenomena, the peculiar form of ataxia which seems to be in a measure under the patient's control, the variability in the symptoms and the improvement, which, though slight, is appreciable, have led to a diagnosis of hysteria.

Dr. Mills stated that the patient had been under his care at one time at the University Hospital. He had examined her several times very carefully, and became satisfied, after she had been under his observation for some time, that the case was one of organic disease, notwithstanding the fact that she presented a few of the classical symptoms that are supposed to clearly indicate the presence of hysteria. He did not believe the contractions of the visual fields are undoubted evidence of hysteria, as they are known to occur in other diseases, and sometimes in health. He stated that the patient did not seem to be any better than when he had first seen her, the ataxia of station and gait being no less marked. She still has a marked, persistent ankle clonus on the right side, and clonus on the left side, which is not so persistent. She has, also, the Babinski reflex on both sides. He stated that if the case were not one of pure hysteria (and he believed it was not) it more closely resembled a case of disseminated sclerosis. He believed it to be one of organic disease, with associated hysterical symptoms.

Dr. Gordon thought that on account of the patient's gait being undoubtedly one of ataxia paraplegia, the marked spasticity, the persistent ankle clonus, and the presence of the Babinski reflex, functional disease could be eliminated. He called special attention to the presence of the Babinski reflex on both sides. According to Babinski's researches and the consensus of opinion of the Paris Neurological Society, when this reflex is persistently present, the case must be organic and cannot be functional. He also thought the presence of ankle clonus with the other symptoms, pointed almost certainly to organic disease. While the patient does present symptoms of hysteria, he believed them to be associated symptoms.

Dr. Spiller stated that he had seen and lectured on the patient at the Woman's Hospital about three years ago; that she had been under his care a long time at the University Hospital, and he was not surprised that a diagnosis of hysteria had been made. He believed she had improved somewhat, but never to a marked degree, and he had long since given up the diagnosis of pure hysteria in the case, and believed it to be a case of disseminated sclerosis, with hysterical manifestations.

Dr. Dercum believed the case to be one of organic nervous disease, and although the patient had hysterical symptoms he thought it very unlikely that the case was one of hysteria alone.

Dr. Peter, in closing the discussion, stated that he had brought the patient before the Society because he thought the case was of sufficient interest to provoke discussion. When she first came to the clinic she was thought to have disseminated sclerosis, plus hysteria, but after examination from week to week he felt that the hysterical element predominated. Even though the Babinski reflex was present, it seemed to him that the case was one of hysteria only.

A Case of Trauma of the Cervical Spine Exhibiting Syringomyelic Symptoms.—This case was reported by Dr. J. H. W. Rhein.

Dr. Alfred Gordon said that Dr. Rhein's case was identical in its clinical manifestations with the case exhibited by him (Dr. Gordon) before the County Medical Society in June, 1904. His was one of gunshot wound in the neck; bullet penetrating at the level of fifth cervical vertebra. The patient presented a motor paralysis on one side and a sensory paralysis on the other. Both conditions covered an entire half of the body. Dr. Gordon made a diagnosis of Brown-Séquard's paralysis, as it reminded him in the main features, as well as in detail, of the experimental results obtained in animals by that great physiologist. He, therefore, believed Dr. Rhein's case to be one of Brown-Séquard's paralysis.

A Case of Myokymia with Remarks Upon the Different Forms of Tonic and Clonic Myospasm.—This case was presented by Dr. C. K. Mills. The muscular twitchings are not always present. The patient is twenty years of age and very tall, over six feet, and has grown very much in the last two years. He is a student. One year ago he suffered with pain in the back of the head and neck, and had difficulty in concentrating his mind on his work. He also became easily exhausted physically. About this time he noticed at intervals muscular twitchings in different parts of the body, in the calves of the legs, thighs and the muscles of the shoulders, and between the shoulder and arm. These twitchings are so marked that he can not only feel them but can also see them. Formerly they were cramp like, but this is not the case any longer. He has no other symptoms except attacks of dizziness or a feeling of faintness on exertion. He has always been thin. The question of diagnosis was between fibrillary tremor or some peculiar form of cramp-like movement, or the so-called myokymia or myospasm of unknown pathology, usually supposed to be functional and connected with a neurasthenic state.

Dr. Dercum thought the whole subject of myospasm a very obscure one. A large number of myospasms do not seem to be related at all to fatigue symptoms, and again there is another group in which fatigue symptoms are a pronounced factor. He cited the case of a young school teacher in whom the condition was present in both arms. There was a prolonged period of fatigue before the muscle spasms became pronounced. At the present time her condition improves with rest and becomes worse with fatigue. Fatigue myospasms of the extremities are probably related to the muscular twitchings observed in neurasthenic states in the muscles of the calves, and in individual bundles of the frontalis and other facial muscles.

Dr. Spiller did not think the case was one of organic disease, and agreed with Dr. Mills' diagnosis. He called attention to a case of unilateral muscular twitching of the face he had reported. The man lived a long distance from Philadelphia, and was not seen until about a year after the first examination, at the later period the myokymia had developed into a convulsive tic.

Dr. Eshner stated that he had often noticed, in his own person, especially when much fatigued, a twitching of the muscles below the lower lip and above the eyebrow.

Dr. Sinkler thought that the case was clearly related to that form of muscular spasm of the orbicularis palpebrarum, associated with fatigue or neurasthenia, or with the excessive use of tobacco.

Dr. Mills, in closing the discussion, stated that he considered the case peculiar in that the myospasm was distributed over such scattered areas, not being limited to the brow or face. The condition was made worse by exertion, and came on while the patient was working and studying very hard. He advised physical and mental rest, combined with suitable tonics.

A New Reflex: Paradoxic Flexor Reflex.—Dr. Gordon described and demonstrated a new reflex which had the same diagnostic value as exaggerated knee-jerks and Babinski's sign. He found it always present in association with increased patellar tendon reflex. He examined thirty cases of various organic diseases of brain and cord, in which an involvement of the motor tract was diagnosed from the classical symptoms, In these cases the Babinski's toe phenomenon was present, or only slightly marked, or entirely absent. Curiously enough in the majority of his cases Dr. Gordon found a sort of antagonism between the paradoxic flexor reflex and Babinski's sign: as they showed a tendency to replace each other. The value of this new reflex is particularly appreciated in those obscure cases in which Babinski's is either absent or very slightly marked, and a diagnosis of an organic disease is in doubt. The author cited a case of trauma to the back, observed at the Jefferson Hospital, in which this reflex was present some time before Babinski's made its appearance, but the knee-jerk was markedly exaggerated. He also observed the reflex on the non-paralyzed side in hemiplegia, in which, as is known, there is almost always found an exaggerated knee-jerk, and in which the non-decussating homolateral tract is supposed to be involved.

The paradoxic flexor reflex is, therefore, a sign pointing to an involvement of the motor tract. For the purpose of control Dr. Gordon examined 200 normal individuals, also individuals with organic diseases of other portions of the cerebro-spinal system (not of the motor tract), also cases of paralysis agitans with increased knee-jerk, and in all the paradoxic reflex was absent. The reflex is elicited in the following manner: The patient is sitting with his feet (not legs) on a stool. The examiner, who is always on the outer side of the patient, places his thenar and hypothenar on the inner side of the tibia, and with the fingers exercises deep pressure on the calf muscles (the pressure must be deep in order to be transmitted to the flexor muscles) ; the great toe, or all the toes, then extend. It requires some practice to elicit this reflex, but it is easily and distinctly produced.

Dr. Pickett thought this reflex exceedingly interesting, but that it bore a marked relation to Oppenheim's reflex, brought out by stroking firmly along the inner border of the tibia.

Dr. McCarthy stated that Dr. Gordon's reflex impressed him as a new method of bringing out Oppenheim's reflex. He thought Dr. Gordon's method of eliciting the reflex was an improvement over Oppenheim's method.

Dr. Mills did not think the reflex was to be considered the same as Oppenheim's reflex. He thought that all of these reflexes—Oppenheim's, Babinski's and Gordon's—are significant of the fact that the nerves that supply the musculature of the toes will produce a reverse movement, and various means of producing the same movement may be obtained.

Dr. Spiller stated that he also had been thinking of the resemblance to Oppenheim's reflex. He suggested that it would be well to determine in what proportion of cases the extension of the toes, as obtained by Oppenheim's method, was associated with extension of the toes as obtained by Gordon's method.

Dr. Dercum thought this reflex different from a skin reflex, as it was produced by deep pressure of the muscles. It does not resemble Oppenheim's reflex, but is something different and entirely new. He thought that if we have here another reflex that will help to differentiate between functional and organic disease it will be very valuable.

Dr. McCarthy stated that Oppenheim's reflex is not a skin reflex, in as much as Oppenheim takes the blunt end of a percussion hammer and presses deeply in the muscle.

Dr. Gordon, in closing the discussion in regard to this reflex, stated that in making deep pressure, as he did in bringing out his reflex, he irritated the gastrocnemius and deep flexors, and instead of getting flexion he obtained extension. He did not think it had anything to do with Oppenheim's reflex. Neither did he think it had anything to do with Babinski's reflex, which was obtained by irritating the skin of the sole of the foot. By pressing upon the flexors he got extension, and he thought this was certainly a paradoxical reflex. He had examined thirty cases, in a number of which the Babinski sign was absent, while his own reflex was present. There is a certain practical value in this reflex, because when Babinski's sign is absent there is a doubt whether the disease is organic or functional, and in these cases he thought his reflex would aid in the diagnosis. He had always found it present in cases with exaggerated knee-jerks, and never found it in cases of tabes, or in normal individuals. In hysteria it was absent. In paralysis agitans it was absent. He stated that he had made a study of this reflex for some months, thinking it a modification of Babinski's or other reflexes, but upon careful study he found it different, as it has relation only to stimulation of the flexor muscles; the tibialis posticus and peronei have a function different from flexion or extension of the toes.

Neuro-fibrillary Changes.—Dr. Ludlum made a preliminary report on this subject.

Dr. Pickett thought that if the neuro-fibrils, as Apàthy believes, are the conducting element of the cell, in them we should look for changes in some forms of insanity; and in accordance with Dr. Mills' suggestion about two years ago, when Shaffer's Weigert studies of the paretic brain appeared, it would seem that this method should be useful in comparative studies of different parts of the cortex. If a difference were noted in the destruction of the fibrils in different parts, the consideration of a number of findings should prove of much value. He thought this method a distinct advance over the method of Nissl for the study of insanity.

A Case of Mixed Aphasia, with Hyperesthesia and Partial Hemianopsia in a Left Hemiplegic.—Dr. Mills and Dr. Weisenburg reported this case. Dr. Mills thought the case an interesting one on account of the left hemiplegia and the aphasia. Whether the patient was a right-handed man he thought was open to doubt. He believed the man was ambidextrous. He could use his left hand with a great deal of facility, and his right hand for writing. It is a well-known fact that some persons who are born left-handed may be taught to write with the right hand, although they perform other acts with the left hand.

Dr. Dercum thought the explanation was that the man was left-handed. He thought that the majority of ambidextrous people are really left-handed, and are merely educated to use the right hand.

Dr. Weisenburg thought the patient would be considered a right-handed individual.